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Issue Date: 12 January 2006

***In the Matter of*:**

BILLY MILES ROSE,
Claimant,

v. CASE NO: 2003 BLA 6381

CONSOLIDATION COAL COMPANY
OF KENTUCKY, INCORPORATED,
Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

***Appearances*:**

Zaring P. Robertson, Esq.
For the Claimant

Natalee Gilmore, Esq.
For the Employer

Before: Edward Terhune Miller
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

Statement of the Case

This proceeding involves an initial claim for benefits filed under the Black Lung Benefits Act, as amended, 30 U.S.C. § 901 *et seq.* ("Act"), and the regulations promulgated thereunder.[1]

[1] All applicable regulations which are cited in this Decision and Order are included in Title 20, Code of Federal Regulations, as amended and effective January 19, 2001, and are cited by part or section only. The Director's exhibits are denoted "D-"; Claimant's exhibits, "C-";

Since Claimant filed this application for benefits after March 31, 1980, Part 718 applies. *Saginaw Mining Co. v. Ferda*, 879 F.2d 198, 204, 12 BLR 2-376 (6th Cir.1989). This claim is governed by the law of the United States Court of Appeals for the Sixth Circuit, because the Claimant was last employed in the coal industry in the Commonwealth of Kentucky. (D-3). *See Kopp v. Director*, *OWCP*, 877 F.2d 307, 12 B.L.R. 2-299 (4th Cir. 1989); *Shupe v. Director*, *OWCP*, 12 B.L.R. 1-200 (1989) (*en banc*).

Billy Miles Rose (the "Claimant") filed the instant claim on July 6, 2001. (D-2). On April 26, 2002, the District Director issued a *Schedule for the Submission of Additional Evidence*, indicating that at that time Claimant would be entitled to benefits based on the record as developed, and that Consolidation Coal Company of Kentucky was the appropriate responsible operator. (D-11). On February 3, 2003, the District Director issued a *Proposed Decision and Order – Award of Benefits – Responsible Operator*. (D-12).

On May 7, 2003, the Employer requested a formal hearing, and on August 1, 2003 the claim was referred to the Office of Administrative Law Judges. (D-17) The hearing was conducted before the undersigned on July 27, 2004 in Hazard, Kentucky. Claimant's Exhibit A (C-A), Director's Exhibits 1-17 (DD-1-17), and Employer's Exhibits 1-8, "A" (EE 1-8, "A") were admitted into evidence. (Tr. 7, 21, 24, 38, 41). Employer's Exhibits 9-14 were marked for identification (Tr. 21), but the issue of their admissibility reserved.

Issues

1. Whether Claimant suffers from pneumoconiosis.
2. If so, whether Claimant's pneumoconiosis arose out of his coal mine employment.
3. Whether Claimant suffers from total respiratory disability.
4. Whether such total respiratory disability, if proved, is due to pneumoconiosis.

Employer withdrew from controversion whether the Claimant has a qualified dependent, and whether Consolidation Coal Company of Kentucky qualifies as the responsible operator.[2] The parties stipulated to 25 years of coal mine employment. This stipulation is supported by substantial evidence. (Tr. 8-9).

FINDINGS OF FACT

Background

Claimant, Billy Miles Rose, was born on October 8, 1954, and was 49 years old at the time of the formal hearing. (Tr. 20). He is unmarried and has no qualifying dependents. (Tr. 19). He testified that he started smoking at age 18 and quit three years before hearing at age 45.

Employer's exhibits, "E-"; and citations to the transcript of the hearing, "Tr."

[2] Employer preserved for appeal issues relating to the constitutionality of the regulations as amended, as well as the validity of the evidentiary limitations. (Tr. 9).

He smoked one "or less" pack per day. (Tr. 20).

Claimant spent 18 years of his work in the mines operating a continuous miner which exposed him to very dusty conditions. (*Id*.). This machine cuts coal at the seam or coal face and loads the product onto a conveyor for placement into shuttle cars. (Tr. 10-11). This was Claimant's last coal mine job. (Tr. 12). Claimant testified that this job also required him to carry a 12 to 15 pound "remote control box" to control the machine, and to "slide" the "miner cable" (weighing nearly 200 pounds) as part of his maintenance responsibilities. (Tr. 12, 15). He also would look after a water line that was employed to cool the machinery. (*Id*.).

Claimant testified that he started to experience breathing problems and other difficulties two to three years before he left the mines in June, 2001. (Tr. 15-16). He said that he left because of his breathing – he was told he had "black lung" and emphysema. (Tr. 16). He has applied for Social Security and state black lung benefits. These applications are pending.

Claimant said that his breathing limits his ability to engage in daily activities such as walking and completing jobs around the house. (Tr. 17). He uses a nebulizer four times a day and an inhaler. (Tr. 18).

Medical Reports and Opinions

Dr. Glen Baker

Dr. Baker, who is board-certified in internal medicine and pulmonary diseases, but was not a B-reader at the time of the examination, examined Claimant on October 3, 2001 at the request of the Department of Labor, and submitted his conclusions in a report of this examination on October 3rd. (D-8). Dr. Baker recorded a patient history that included complaints of wheezing attacks and chronic bronchitis. These conditions had been continuing for the previous two to three years. Claimant also told Dr. Baker that he had suffered from arthritis and high blood pressure three to four years for the former and one year for the latter condition. He had undergone a lung biopsy in 2000, which resulted in a diagnosis of "black lung." Dr. Baker also recorded a cigarette smoking history of 26 years at the rate of 1/2 pack per day initially, and later "1/4 PPD."

Claimant's current complaints to Dr. Baker included wheezing on a daily basis, a daily productive cough and three-pillow orthnopnea. These conditions had become manifest two or three years previously. In addition, Claimant has suffered from dyspnea on exertion, feeling the effects of walking 300 feet on level ground. When he suffers from shortness of breath at night, he uses an inhaler or nebulizer.

On physical examination, Dr. Baker observed "bilateral expiratory wheezes" on auscultation of the chest, but listed no other positive findings. From diagnostic testing, Dr. Baker reported that a chest x-ray showed "Coal Workers' Pneumoconiosis 1/0," pulmonary function studies demonstrated a "moderate obstructive defect," arterial blood gas study results were "within normal limits," and the EKG indicated a "normal sinus rhythm." Dr. Baker diagnosed coal workers' pneumoconiosis, 1/0, based on abnormal chest x-ray & coal dust

exposure, and attributed to coal dust exposure; chronic bronchitis based on a history of cough, sputum production and wheezing, attributed to coal dust exposure/cigarette smoking; and chronic obstructive pulmonary disease (COPD) with moderate obstructive defect, based on pulmonary function tests, and attributable to coal dust exposure/cigarette smoking.

In assessing impairment, Dr. Baker opined that these diagnoses were "fully" responsible for a "moderate [impairment] with decreased FEV1, (54%), chronic bronchitis and Coal Workers' Pneumoconiosis 1/0[.]" On a separate form, Dr. Baker reiterated his conclusion that Claimant suffered from an occupational disease which was caused by his coal mine employment, that Claimant suffered from a "moderate impairment," and that, as a result, he "did not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment." When prompted to provide a "detailed rationale," for the disability assessment, Dr. Baker noted "FEV1 54%[.]" (D-8).

Dr. Thomas M. Jarboe

Dr. Jarboe, who is board-certified in internal medicine and pulmonary disease, and a B-reader, evaluated the Claimant on July 16, 2003 at the request of the Employer. He submitted his report of this examination on July 17, 2003. (E-3). He had earlier examined Claimant on May 13, 2003 in connection with his claim for state benefits.

Dr. Jarboe reported a coal mine employment history of 27 years, ending when Claimant was removed from mining because of his lungs. Claimant told the doctor that he wore a respirator about "50% of the time."

Claimant complained that he smothers often, and that problems with his breathing have persisted for about five to six years and are worsening. He reported that he is constantly short of breath; that he must remain indoors during hot weather; and that his breathing problems awaken him almost every night, so that he must get up and sit in a recliner. He gets short of breath walking less than 100 yards on level ground, or climbing 14 steps. He complained of a daily productive cough and occasional wheezing. Dr. Jarboe recorded a smoking history of one pack of cigarettes per day from age 19 until early 2001 – about 26 years. He also noted that Claimant had undergone a bronchoscopy and lung biopsy in June, 2001, after which Dr. Alam told him that he had "black lung."

On physical examination of the chest, Dr. Jarboe observed no dullness, and "[g]ood air entry and distribution into all zones." He detected no rales or wheezes, clubbing, or edema. Dr. Jarboe reported that the ventilatory study results suggested mild restriction and obstruction, with some response to the administration of bronchodilators. The "post dilator FVC and FEV1 exceeded the Federal limits for disability in coal miners[,]". The "lung volumes showed a normal total lung capacity." Dr. Jarboe opined that Claimant had "no true restriction," and added that his "residual volume and RV/TLC ratio are significantly elevated indicating air trapping." The arterial blood gases demonstrated a PO2 at the lower limit of normal.

Dr. Jarboe's cardiopulmonary diagnoses were bronchial asthma, based on a history of episodic wheezing worsened with hot, humid weather, and treatment plans indicating that

Claimant has bronchial asthma; significant obesity; and essential hypertension. Dr. Jarboe opined that there was insufficient evidence to justify a diagnosis of coal workers' pneumoconiosis because the x-ray evidence was negative, and

> pulmonary function studies do not support a diagnosis of a dust induced lung disease. He has no restrictive disease. While it appears he might have restriction on spirometry, the lung volumes show that his total lung capacity is completely normal. The reduced vital capacity is due to air trapping. This air trapping in turn is most likely due to cigarette smoking and bronchial asthma. There is a reversible component to the airflow obstruction which also argues against dust inhalation as causative. Coal dust inhalation causes a fixed, not a reversible component.

Dr. Jarboe opined that Claimant has a mild respiratory impairment "in the form of mild airflow obstruction which is partially reversible. … [T]his mild airflow obstruction has been caused by a combination of cigarette smoking and asthma." He did not believe, however, that Claimant was totally disabled from a pulmonary or respiratory impairment, and found "no respiratory disease which has been caused by or substantially contributed to by coal dust inhalation."

Dr. Gregory J. Fino

Dr. Fino, who is board-certified in internal medicine and the subspecialty of pulmonary disease and a B-reader, examined Claimant on September 25, 2003, and submitted a report dated October 14, 2003. (E-4). He recorded that Claimant was taking numerous medications, including using a nebulizer and inhalers, identified as "Albuterol sulfate, Ipratropium bromide and Flovent." Dr. Fino recorded a smoking history of 31 years at the rate of one pack per day from 1970 until 2001, and a coal mine employment history of 27 years of underground work ending in 2001.

Claimant complained of breathing difficulties, characterized by shortness of breath, that have persisted for ten years prior to the examination. Although Dr. Fino noted that "[i]t does not interfere with [Claimant's] usual daily activities[,]" he reported that Claimant "does become dyspneic when walking at his own pace on the level ground or ascending one flight of steps ... up hills or grade, lifting and carrying, performing manual labor, and walking briskly on the level ground." Dr. Fino also recorded complaints of wheezes, chest pain, but denial of orthopnea and paroxysmal nocturnal dyspnea. Claimant's past medical history included a lung biopsy in 2001, a diagnosis of "black lung" that same year, a hospitalization in 2003 for lung problems and emphysema. He suffers from frequent colds, high blood pressure and diabetes. The "review of symptoms" was negative.

On physical examination, Dr. Fino observed "decreased breath sounds with a prolongation of the expiratory phase" in examination of the lungs. There was no edema and the examination of the extremities was negative. Dr. Fino interpreted a chest x-ray as negative for pneumoconiosis. The pulmonary function study showed a "moderate obstruction with no bronchodilator response." That test also revealed that the "TLC [total lung capacity] is normal and air trapping is present[,]" and the diffusing capacity was "normal." Based on the arterial

blood gas test results, Dr. Fino concluded that Claimant's oxygen saturation was normal. Dr. Fino also reviewed some of Claimant's medical records. He diagnosed "chronic obstructive pulmonary disease [due to] cigarette smoking," which he explained:

> [I]t is my opinion that this man does not suffer from coal workers' pneumoconiosis based on the following:
>
> 1. My reading of the chest x-ray is negative for pneumoconiosis.
> 2. There is an obstructive abnormality present. I believe that the obstruction is related to cigarette smoking. I will discuss this in greater detail later in the report.
> 3. The diffusing capacity values are normal. A normal diffusing capacity rules out the presence of clinically significant pulmonary fibrosis.
> 4. The TLC was not reduced and this rules out the presence of restrictive lung disease and significant pulmonary fibrosis.

Dr. Fino also opined that from a functional standpoint Claimant's pulmonary system is "abnormal;" and Claimant as disabled from a respiratory standpoint from returning to his last coal mine work. Although Dr. Fino noted that two risk factors were present – coal mine dust exposure and smoking, he attributed Claimant's disability solely to the latter:

> In this instance, the clinical information is consistent with a smoking related disability. Even if chronic obstructive lung disease due to coal mine employment contributed to the obstruction, the loss in the FEV1 would be in the 200 cc range. If we give back to him that amount of FEV1, this man would still be disabled. This medical estimate of loss in FEV1 in working miners was summarized in the 1995 NIOSH document. Although a statistical drop in the FEV1 was noted in working miners, that drop was not clinically significant. This man would be as disabled had he never stepped foot in the mines.

In reaching his conclusions, Dr. Fino further stated that, even assuming the existence of pneumoconiosis, that disease has not contributed to Claimant's total disability, and opined that he "would be as disabled as I find him now had he never stepped foot in the mines."

X-Ray Evidence[3]

The following x-ray interpretations have been submitted for this claim:

Exh. No.	X-ray Date Reading Date	Physician	Qualifications	Film Quality	Interpretation
D-8	10-03-01 10-03-01	Baker	B	2	1/0, p/p

[3] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "BCR".

Exh. No.	X-ray Date Reading Date	Physician	Qualifications	Film Quality	Interpretation
D-8	10-03-01 10-30-01	Sargent	B/BCR	1	quality reading
E-2	10-03-01 06-12-03	Wiot	B/BCR[4]	2	negative for pneumoconiosis
E-3	07-16-03 07-16-03	Jarboe	B	1	negative for pneumoconiosis
E-4	09-25-03 09-25-03	Fino	B	1	negative for pneumoconiosis

Biopsy

Dr. P. Rapheal Caffrey

Dr. Caffrey, who is a board-certified pathologist, examined a pathology report and related histolic slides produced from a biopsy conducted on July 20, 2001, by Dr. Shiu-Kee Chan at the Appalachian Regional Healthcare and Hazard-ARH Hospital.[5] (E-5). Based on his review of the biopsy specimen, which consisted of "four biopsy fragments from the lower lung lobe" and a slide six small fragments of lung tissue, Dr. Caffrey reported on February 18, 2004 that the biopsy showed, *inter alia*, anthracotic pigment. He concluded, however, that

> … The biopsy material is insufficient to disprove the existence of CWP.
>
> The amount of anthracotic pigment in this patient's lungs certainly would not by itself have caused any significant pulmonary disability … particularly since the findings required to make a diagnosis of CWP definitely are not present on this biopsy slide. The microscopic sections show only a mild amount of anthracotic pigment and there are no birefringent crystals consistent with free silica noted in the sections. …

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[4] Dr. Wiot has been Professor Emeritus of Radiology at the University of Cincinnati since 1998, and was Professor of Radiology at that university from 1966-1998. He was President of the American Board of Radiology, and the American College of Radiology, from 1982 to 1984. (E-2). Although academic experience does not require that a radiologist's interpretation must be credited, *see Chaffin v. Peter Cave Coal. Co.*, 22 B.L.R. 1-294 (2003), such experience is a relevant factor. *Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993).

[5] Claimant did not submit records from the hospitalization, including the biopsy report that resulted in a diagnosis of "black lung." (*See* Tr. 34).

(E-5).

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. These tests are also acceptable documentation for a medical opinion diagnosis of pneumoconiosis. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for pulmonary function studies performed before January 19, 2001, are found at § 718.103 (2000), while the standards applicable to tests administered after that date are set forth at § 718.103 (2004) and Appendix B. In the following chart which summarizes the results of the pertinent pulmonary function studies, "Post" refers to the administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. § 718.204(b)(2)(i) (2004).

Ex. No. Date Physician	**Age Height**[6]	**FEV_1 Pre-/ Post**	**FVC Pre-/ Post**	**FEV_1/ FVC Pre-/ Post**	**MVV Pre-/ Post**	**Qualify**	**Impression cooperation comprehension tracings**
D-8 10-03-01 Baker	46 71.75"	2.32	3.99	58%	57	Yes	"fair" cooperation; "good" comprehension. Tracings are attached; "moderate obstructive defect"
E-3 07-16-03 Jarboe	48 183 cm [72.05"]	2.28 2.50 (post)	3.78 3.94 (post)	60% 63% (post)	94 89 (post)	Yes No	cooperative, fairly good effort and technique "mild restrictive and obstructive ventilatory defect" improvement after bronchodilators ... does not reach significance

[6] Claimant's height has been measured at 71.75, 72 and 72.05 inches. His height for purposes of evaluating the pulmonary function study results is 72 inches. *See Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). *See also Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116, 19 B.L.R. 2-70 (4th Cir. 1995).

Ex. No. Date Physician	Age Height[6]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify	Impression cooperation comprehension tracings
E-4 09-25-03 Fino	48 72"	2.28 2.36 (post)	3.59 3.85 (post)	63% 61% (post)		No No	"fair patient effort"

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The quality standards for arterial blood gas studies performed before January 19, 2001, are found at § 718.105 (2000), while the quality standards for tests conducted subsequent to that date are set forth at § 718.105 (2004). A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. § 718.105(b) (2000); § 718.105(b) (2004).

Exhibit Number	Date Altitude	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify	Impression
D-8	10-03-01 <2999'	Baker	41	84	No	within normal limits; test considered "acceptable" by Dr. Michos (D-8)
E-3	07-16-03	Jarboe	39.9	76.9	No	
E-4	09-23-03	Fino	43.4	76.9	No	

Treatment Records

The Employer has submitted medical records gathered from the Appalachian Regional Healthcare and the Mountain Comprehensive Health Corporation. (E-1). Included in this exhibit is the interpretation of a CT scan taken on April 25, 2000, by Dr. E. Kabir, who observed:

> ... There is considerable focal enlargement of the left pulmonary artery which probably causes the enlargement of the left hilum. No evidence of any abnormal mass or lymphadenopathy is seen. Right hilum appears normal. Lung parenchyma appears unremarkable. Mediastinum appears normal. Pleural surface, as well as, pericardium and myocardium appear normal.

(E-1). Dr. Kabir saw this as a "[n]egative pre and post-contrast CT scan of the chest." He also

concluded that the "left hilar enlargement is probably related to the prominent pulmonary vessel. (E-1).

These treatment records also include the interpretations of several chest x-rays. Dr. A. Hashem read a June 5, 1997, x-ray as a "negative chest." The lungs were "clear." This x-ray was sought to rule out pneumonia. Two chest x-ray views from March 3, 2000, showed that the "lung fields were clear of active process." Dr. E. Kabir interpreted a chest x-ray dated June 6, 2001, as demonstrating "[n]o definite active process in the lung field[.]" He noted that the lung fields were "clear of active process." (E-1). Dr. Pampati interpreted a film taken on October 16, 2001, as showing "[n]o evidence of pleural effusion or pneumothorax." He recommended a "contrast enhanced" CT scan. (E-1). Dr. W. Gabier saw no active disease in a chest x-ray interpreted on December 19, 2002. Lungs were "clear" on that film as well. (E-1). Earlier, Drs. Desai and Pampati reached similar conclusions with their interpretations of films dated January 17, December 6 & 13, 2002. (E-1). On January 3, 2003, Dr. Robert Buck read a chest x-ray as showing, *inter alia*, clear lungs. He also noted that the "[p]ulmonary hila are slightly prominent, which may be due to inflammatory adenopathy." Dr. Buck's impression was that the film showed "no acute process." (E-1).

Deposition Testimony

Dr. Thomas M. Jarboe

Dr. Jarboe's deposition testimony was recorded on July 14, 2004, regarding his examination of Claimant on July 16, 2003, as well as his review of certain of Claimant's medical records. (E-6). He opined that Claimant's 27 years of coal mining would be sufficient to cause lung disease. (E-6 at 9). He also recorded a 30 pack/year history of cigarette smoking. Basing his conclusion on Dr. Caffrey's interpretation of the biopsy, Dr. Jarboe opined that the biopsy did not establish the existence of pneumoconiosis. (E-6 at 11-12). Dr. Jarboe denied that Claimant's medications are of the type to treat a coal dust induced lung disease, "[b]ecause they are specifically designed to treat airway disease that is involved or that it is caused by bronchial asthma." He said that medications such as Flovent would be used to treat asthma. (E-7 at 13-14).

Dr. Jarboe explained how a pulmonary function study is effective in the diagnosis of pneumoconiosis. He explained that black lung

> usually causes some element of restriction of the vital capacity and it may or may not cause some airflow obstruction, but it definitely can cause both. So spirometry can be used to determine if these elements are present. The other use of spirometry is to determine the degree of impairment. … Lung volumes really help you in the differential diagnosis and help to confirm the findings on spirometry. … [R]educed vital capacity can be due to scarring and fibrosis which in turn could be due to coal dust inhalation, or it could be due to air trapping due to airway disease and asthma. The lung volumes help sort out causation of an abnormal spirogram and, therefore, help you in the differential diagnosis. Again, this case is a good example of that in that Mr. Rose had a vital capacity that was

> reduced. You could easily see that in coal dust induced disease, yet his total lung capacity on the lung volumes was entirely normal. His residual volume or the degree of trapped air was high. This means that Mr. Rose's vital capacity is low because – not because he has fibrotic lung, but because he has trapped air in his lungs which prevents him from taking a deep breath.

(E-6 at 15-16). Dr. Jarboe continued that

> [t]here was some response to bronchodilating agents, although it did not quite reach significant levels. The lung volumes showed that his total lung capacity was completely within normal limits; thus, there was no true restriction in this case. The vital capacity was reduced for other reasons and that reason becomes apparent when you see that his residual volume is 128 percent of normal, again, meaning that he has significant trapped air in his lung which prevents him from taking a deep breath. So his lung volumes show mild air trapping. The diffusion capacity is completely normal … but this combination of findings would be quite characteristic of a person who had bronchial asthma or who had airway disease from smoking cigarettes.

(E-6 at 17-18).

Dr. Jarboe acknowledged his familiarity with the broad definition of pneumoconiosis as that disease is defined under the Act, and opined that Claimant does not have pneumoconiosis:

> [H]e doesn't have medical pneumoconiosis[.] … He does have a respiratory impairment … but after reviewing all of the data, in my opinion, his impairment is not caused by his occupation as a coal worker. I feel that it has been caused by a combination of 30 pack-years of smoking cigarettes and the fact that he has bronchial asthma. I base that opinion primarily on the fact that he has a well preserved total lung capacity … which is normal, and the fact that the medical records, in my opinion, do support the fact that he has asthma. … In my opinion, the functional abnormalities are more compatible with causation by smoking and/or asthma than by dust inhalation.

(E-6 at 20-21). Dr. Jarboe emphasized that the normal total lung capacity would be unusual in a dust induced disease. (E-7 at 22). He also cited the existence of some reversibility, and explained that coal dust inhalation does not cause reversible airways disease. (*Id*.).

Dr. Gregory Fino

Dr. Fino's deposition testimony, recorded on July 14, 2004, elaborated on his examination of Claimant and his review of pertinent medical records. (E-7). Dr. Fino noted Claimant's pulmonary complaints of shortness of breath, productive cough, wheezing and chest pain are not specific to any one disease, and that Claimant had been taking medications "primarily used in asthma [f]or people who wheeze." (E-7 at 8). Dr. Fino declared that asthma is not caused by coal dust exposure. (E-7 at 8). He also testified that coal workers'

pneumoconiosis results in a fixed, not reversible, respiratory impairment.

Dr. Fino opined that the results of a lung biopsy did not establish pneumoconiosis. Because the procedure employed a bronchoscope, Dr. Fino opined that the size of the tissue pieces would generally be very small – "way too small to make any diagnoses, other than generally a malignancy," and that the pathologist's finding of anthracotic pigment alone would not be a sufficient basis to make a diagnosis of coal workers' pneumoconiosis. (E-7 at 9). Dr. Fino explained that one would also have to find "macules of coal dust and pulmonary fibrosis and emphysema together."

Dr. Fino testified that the results of his pulmonary function testing demonstrated the presence of "a moderate obstruction [with] no improvement after the administration of bronchodilators." (E-7 at 11). He identified two "risk factors," smoking and coal mine dust inhalation, and attributed Claimant's moderate obstruction to smoking. Dr. Fino explained:

> The issue at hand, of course, is whether or not his 27 years of working in the mines caused a problem. And that 27 years was primarily all after dust regulations. And studies from NIOSH, specifically a study by Dr. Attrfield … documented that you would lose, due to coal mine dust on average, three cc's a year for each year worked. So if he worked 27 years, three times 27 is 81 cc's. This man has lost way more than that, probably has lost two liters total. So the 81 cc's would only represent a very insignificant portion of the total loss of FEV-1.
>
> Now, what you need to do is look for some evidence that this man may be more susceptible to coal mine dust. I don't see any evidence such as that. The primary one is evidence of significant coal dust retention, and you can see that radiographically, but I didn't see anything radiographically.
>
> Now, important to say I'm not ruling out coal workers' pneumoconiosis because the X-ray is negative. But all the studies have shown that the amount of coal dust that you inhale is directly proportional to the amount of obstruction you have, which is directly proportional to the chest x-ray. Well, I don't see any reason that he has more than an average loss of FEV-1 due to coal dust. So 81 cc loss, even if you take some of the studies which I referred to in my report and put it up to a 200 cc loss … it still is not significant. Meaning that he would be as disabled as I find him now had he never stepped foot in the mines, it's all due to smoking.

(E-7 at 11-13).

Dr. Fino explained why, in his opinion, Claimant does not suffer from pneumoconiosis "or any other lung disease that's been caused by, related to, or aggravated by coal dust exposure":

> The pattern and amount of obstruction is most consistent with smoking … he doesn't have any evidence of lung destruction since the diffusing capacity is

> normal. That would be unusual in a coal dust related condition, that is, not to have lung destruction.
>
> Also the normal diffusing capacity indicates that he has no problem getting oxygen from the air sacs to the bloodstream. I believe that Dr. Jarboe also had a normal diffusing capacity. Everything points to a smoking related condition in this case.

(E-7 at 14). Dr. Fino acknowledged an awareness of the legal definition of pneumoconiosis, and opined that Claimant does not "have any disease or impairment encompassed by that definition[,]" and categorically denied that Claimant suffers from "any impairment that's been caused by, related to, or aggravated by coal dust exposure." (*Id*.).

DISCUSSION AND CONCLUSIONS OF LAW

Evidentiary Limitations

The applicable regulations, as amended, limit the development of the evidence for claims after their effective date, and apply to this claim. § 725.414. Those regulations preclude consideration of Employer's Exhibits 8-14 because they exceed the evidentiary limitations. (E-9-11). § 725.414(a)(3)(i), (ii). The deposition testimony of Dr. Caffrey is precluded in part from consideration by the regulations. Dr. Caffrey evaluated a biopsy specimen and other medical records. (E-5). His report has been considered solely to evaluate the biopsy since Employer has introduced the medical reports of Dr. Jarboe and Dr. Fino under § 725.414(a)(3)(i). The regulations permit the testimony of a physician who prepared a "medical report admitted under this section." § 725.414(c). Dr. Caffrey's pathology review does not constitute a "medical report" as that term is defined in § 725.414(a)(1). His review of other medical records is likewise precluded by the evidentiary limitations. In addition, the medical report and testimony of Dr. Ghio introduced by Employer are inadmissible because they exceed the numerical limitations under § 725.414(a)(3)(i) and (c). (E-13, 14).

Complete Pulmonary Evaluation

The Director has fulfilled the Department's statutory obligation to provide Claimant with a complete pulmonary evaluation pursuant to Section 413(b) of the Act. 30 U.S.C. §923(b), as implemented by §§ 718.102, 725.405 and 725.406. Dr. Baker evaluated Claimant pursuant to this obligation. The Department of Labor has not satisfied this obligation if the physician who performed the pulmonary evaluation at the request of the Department has not addressed a necessary element of entitlement. *See Cline v. Director*, *OWCP*, 972 F.2d 234, 14 B.L.R. 2-102 (8th Cir. 1992); *Collins v. Director*, *OWCP*, 932 F.2d 1191, 15 B.L.R. 2-108 (7th Cir. 1991); *Newman v. Director*, *OWCP*, 745 F.2d 1161, 1166 (8th Cir. 1984). *See Hodges v. BethEnergy Mines Corp.*, 18 B.L.R. 1-84 (1994). Dr. Baker adequately addressed the essential elements of entitlement.

Pneumoconiosis

For purposes of the Act, pneumoconiosis means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. A disease arising out of coal mine employment includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 30 U.S.C. § 902(b); § 718.201. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. §§ 718.1, 718.202, 718.203 and 718.204 (2004). *Mullins Coal Co., Inc. of Virginia v. Director, OWCP*, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987). *Jericol Mining*, *Inc. v. Napier*, 301 F.3d 703, 708, 22 B.L.R. 2-537 (6th Cir. 2002). The failure to prove any requisite element precludes a finding of entitlement. *Anderson v. Valley Camp of Utah*, *Inc*., 12 B.L.R. 1-111 (1989); *Perry v. Director*, *OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

This claim arises within the territorial jurisdiction of the United States Court of Appeals for the Sixth Circuit. Accordingly, Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at §718.202(a). *See Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc). A finding that pneumoconiosis exists may be based upon x-ray evidence under § 718.202(a)(1); upon the basis of autopsy or biopsy evidence under § 718.202(a)(2); if any one of several cited presumptions are found to be applicable under § 718.202(a)(3). In this case, § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis; § 718.305 is not applicable to claims filed after January 1, 1982; § 718.306 is applicable only to a survivor's claim filed prior to June 30, 1982. The regulations also provide that a miner may establish the existence of pneumoconiosis under § 718.202(a)(4) by a reasoned medical opinion based upon objective medical evidence which supports a diagnosis of pneumoconiosis.

X-Ray Evidence

Greater probative weight may be given to x-ray readings performed by "B-readers" than to interpretations by physicians who possess no radiological qualification. *See Staton v. Norfolk & Western Railway Co*., 65 F.3d 55, 57, 19 B.L.R. 2-271 (6th Cir. 1995). An administrative law judge may properly defer to the readings of the physicians who are both B-readers and board-certified radiologists. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985). *See Zeigler Coal Co. v. Director*, *OWCP* [*Hawker*], 326 F.3d 894, 899, __ B.L.R. 2-___ (7th Cir. 2003). A radiologist's academic teaching credentials in the field of radiology are relevant to the probative value of that expert's conclusions, *see Worhach v. Director*, *OWCP*, 17 B.L.R. 1-105 (1993), although academic experience does not require that the radiologist's opinion must be accorded greater weight. *Chaffin v. Peter Cave Coal. Co.*, 22 B.L.R. 1-294 (2003).

The record includes the interpretations of three x-rays that are classified under ILO-U/C standards. Dr. Baker interpreted the film dated October 3, 2001, as positive. This film was reread as negative by Dr. Wiot. Dr. Baker was not a B-reader at the time of his interpretation, and Dr. Wiot's rereading has greater credibility based on his superior credentials as a dually qualified board-certified radiologist and B-reader with extensive academic experience. *See*

Staton; *Roberts* Because the two other x-rays have also been interpreted as negative for the existence of pneumoconiosis without contradiction, Claimant has not established the existence of pneumoconiosis on the basis of the x-ray evidence.

BiopsyEvidence and Presumptions

Although the biopsy revealed the presence of anthracotic pigment, Dr. Caffrey opined that the single slide specimen developed from this biopsy is essentially inconclusive. Consequently, Claimant has not established the existence of pneumoconiosis under § 718.202 (a)(2). None of the enumerated presumptions apply in this case under § 718.202(a)(3).

Medical Opinion Evidence

Claimant has not established the presence of pneumoconiosis by medical opinion evidence under § 718.202(a)(4). Dr. Baker diagnosed the presence of both clinical and "legal" pneumoconiosis on the basis of a chest x-ray that was reread as negative. *See Winters v. Director, OWCP*, 6 B.L.R. 1-877 (1984). While a medical opinion diagnosis of pneumoconiosis may be sufficient *notwithstanding* a negative x-ray, *see Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1996), where x-ray evidence constitutes a major part of the physician's documentation, his opinion may be given diminished probative weight if the film upon which he relied has been credibly reread as negative and determined by the administrative law judge to be negative. *Cf. Director, OWCP v. Rowe*, 710 F.2d 251, 255 n. 6, 5 B.L.R. 2-99 (6th Cir. 1983) (validity of opinion discounted because doctor relied on x-ray found to be unreadable). Consequently, Dr. Baker's diagnosis of clinical pneumoconiosis is given little weight.

Dr. Baker also diagnosed chronic bronchitis, which he attributed in part to Claimant's coal mine dust exposure, and which would qualify as coal workers' pneumoconiosis notwithstanding the negative x-rays of record. *See Southard v. Director, OWCP*, 732 F.2d 66, 6 BLR 2-26 (6th Cir. 1984). In *Cornett v. Benham Coal Co.*, 227 F.3d 569, 575, 22 B.L.R. 2-107 (6th Cir. 2000), the court emphasized that the "legal" definition of pneumoconiosis "'encompasses a wider range of afflictions than does the more restrictive medical definition of pneumoconiosis.'" (quoting *Kline v. Director*, *OWCP*, 877 F.2d 1175, 1178, 12 B.L.R. 2-346 (3d Cir. 1989)). *See also Mitchell v. OWCP*, 25 F.3d 500, 507 n.12, 18 B.L.R. 2-257 (7th Cir 1994); *Eagle v. Armco Inc.*, 943 F.2d 509, 511 n.2, 15 B.L.R. 2-201 (4th Cir. 1991); *Old Ben Coal Co. v. Prewitt*, 755 F.2d 588, 591 (7th Cir. 1985) (chronic obstructive pulmonary disease meets statutory definition whether or not technical pneumoconiosis). However, an obstructive pulmonary or respiratory impairment must be proved to have been significantly related to or substantially aggravated by Claimant's coal mine dust exposure to qualify as "legal" pneumoconiosis. *See Stiltner v. Island Creek Coal Co.*, 86 F.3d 337, 341, 20 B.L.R. 2-246 (4th Cir. 1996). *See generally* 65 Fed. Reg. 79943 (Dec. 20, 2000) (citing cases).

Dr. Baker's diagnosis of a chronic obstructive pulmonary impairment, attributable in part to Claimant's coal mine dust exposure, constitutes a reasoned medical opinion. A physical examination and history qualifies in the appropriate case as a reasoned medical opinion. *See Gomola v. Manor Mining and Contracting Corp.*, 2 B.L.R. 1-130 (1979). *See also Poole v. Freeman United Coal Mining Co*., 897 F.2d 888, 893, 13 B.L.R. 2-348 (7th Cir. 1990). But "the

documentation underlying their medical judgments, and the sophistication and bases of their diagnoses," must also be considered. *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 B.L.R. 2-269 (4th Cir. 1997). *See Underwood v. Elkay Mining, Inc*., 105 F.3d 946, 950-951, 21 B.L.R. 2-23 (4th Cir. 1997). Accordingly, Dr. Baker's opinion has been evaluated against the medical opinions of Drs. Jarboe and Fino, which persuasively account for the effects of Claimant's many years of coal mine dust exposure in ruling out that exposure in the development of any pulmonary condition.[7] *Cf. Peabody Coal Co. v. Hill*, 123 F.3d 412, 417, 21 B.L.R. 2-192 (6th Cir. 1997) (37 years of coal mine employment).. It has also been weighed against the CT scan evidence.

Drs. Jarboe and Fino commented persuasively on the relationship of coal mine dust exposure and the loss in Claimant's total lung capacity. Dr. Fino emphasized in his deposition testimony that "[t]he pattern and amount of obstruction is most consistent with smoking … he doesn't have any evidence of lung destruction since the diffusing capacity is normal. That would be unusual in a coal dust related condition, that is, not to have lung destruction." (E-7 at 14). Dr. Jarboe also suggested that the level of air trapping would indicate a factor not generally related to coal mine dust exposure.

Ultimately, Claimant has not proved on the basis of the medical opinion evidence that it is more likely than not that his chronic obstructive pulmonary or respiratory disease is significantly related to or substantially aggravated by his coal mine dust exposure. Although Dr. Baker's medical opinion is adequately reasoned, the reports and deposition testimony by Drs. Fino and Jarboe are well explained, more detailed, and incorporate better clinical documentation than the report submitted by Dr. Baker. *See Clark v. Karst-Robbins Corp.*, 12 B.L.R. 1-149 (1989)(*en banc*); *Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985). *See generally Director, OWCP v. Rowe*, 710 F.2d 251, 255, 5 B.L.R. 2-99 (6th Cir. 1983). Balanced against that evidence, Dr. Baker's diagnosis, while rationally based on the limited documentation available to him, does not carry Claimant's burden of persuasion by a preponderance of the evidence. Because Claimant has not established the existence of pneumoconiosis under any provision of § 718.202(a), a requisite element of entitlement, he is not entitled to benefits under the Act.

Total Respiratory Disability

Even if pneumoconiosis were proved, Claimant would have to prove total respiratory

[7] Aspects of the opinions of the Employer's experts do not fully accommodate the broad definition of pneumoconiosis. For example, Dr. Jarboe's evaluation of the pulmonary function study results, and their lack of a demonstrable restriction, may not fully recognize that an obstructive impairment, as that was diagnosed by Dr. Baker, may qualify as coal workers' pneumoconiosis. Dr. Fino emphasized that asthma is not caused by coal mine dust, a view which does not accommodate the construct that coal mine dust exposure need only substantially aggravate a miner's asthma. Also, Dr. Fino's general reference to NIOSH studies that appear to suggest that coal mine dust exposure has lessened with the advent of stricter regulations, is essentially unsupported, although Claimant told Dr. Jarboe that he wore a respirator during half of his employment.

disability. A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f); § 718.204(a), (b) and (c) (2004). Any loss in lung function may qualify as a total respiratory disability. *See Carson v. Westmoreland Coal Co.*, 19 B.L.R. 1-16 (1964), *modified on recon*. 20 B.L.R. 1-64 (1996).

The regulations provide alternative methods to show total respiratory disability other than by the presence of complicated pneumoconiosis: (i) pulmonary function studies; (ii) blood gas studies; (iii) evidence of cor pulmonale; and (iv) reasoned medical opinion. § 718.204(b)(2). Lay testimony may also constitute relevant evidence. *See Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122 (1999). A finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony, however. *See Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). *See also, Fife v. Director, OWCP,* 888 F.2d 365, 370, 13 B.L.R. 2-109 (6th Cir. 1989).

There is no evidence in the record that Claimant suffers from complicated pneumoconiosis or cor pulmonale. Claimant has not established total respiratory disability at § 718.204(b)(2)(i). The preponderance of the pulmonary function study results are not qualifying. Because none of the arterial blood gas tests are qualifying, Claimant has not established total respiratory disability pursuant to § 718.204(b)(2)(ii).

However, Claimant has established total respiratory disability pursuant to § 718.204(b)(2)(iv). Dr. Jarboe opined that Claimant suffers from some respiratory impairment. Drs. Baker and Fino assessed Claimant as totally disabled from a pulmonary or respiratory standpoint. Consequently, it is more likely than not that the medical opinion evidence demonstrates that Claimant is totally disabled. The medical opinion disability assessments in light of Claimant's testimony regarding the nature of his usual coal mine work, support that conclusion. *See generally Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1988).

Finally, the administrative law judge is required to review all relevant evidence, like and unlike, to determine whether a Claimant has established total respiratory disability pursuant to § 718.204(b). *See Shedlock v. Bethlehem Mines Corporation*, 9 B.L.R. 1-195 (1986), *aff'd on recon. en banc*, 9 B.L.R. 1-236 (1987). In the absence of contrary probative evidence, evidence which meets one of the § 718.204(b)(2) standards establishes Claimant's total disability. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Review of all relevant evidence, including the Claimant's testimony, supports a finding of total respiratory disability pursuant to § 718.204(b). Although the clinical tests produced nonqualifying results, they are not sufficient to undermine the medical opinion assessments of total respiratory disability.

Conclusion

Thus, though Claimant has established total respiratory disability, he has not proved by a preponderance of the evidence of record that he suffers from either "clinical" or "legal" pneumoconiosis, and so he has not established entitlement to benefits under the Act.

Attorney Fees

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim of Billy Miles Rose for benefits under the Act is denied.

A

Edward Terhune Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to § 725.479(a).